MISSOURI DEPARTMENT OF MENTAL HEALTH

MARK STRINGER, DEPARTMENT DIRECTOR

DEPARTMENT OPERATING REGULATION NUMBER

DOR 4.180

CHAPTER	SUBCHAPTER	EFFECTIVE DATE	NUMBER OF PAGES	PAGE NUMBER
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SUBJECT	AUTHORITY	HISTORY
Management and Prevention of Choking and Aspiration	Section 630.050, RSMo	See Below

PERSON RESPONSIBLE	SUNSET DATE
Deputy Director	7/1/19

PURPOSE: Prescribes facility responsibilities regarding individuals at risk of choking and aspiration.

APPLICATION: Applies to facilities operated by the Department of Mental Health.

(1) As used in this Department Operating Regulation (DOR), the following terms mean:

(A) Choking: Inhalation or ingestion of any substance, resulting in obstruction of the airway.

(B) Aspiration: Inhalation of food or liquid into the lungs.

(2) Each facility shall have a written protocol that outlines procedures for the prevention and management of choking and aspiration. Based upon training received regarding each facilities choking and aspiration prevention/management as well as emergency procedures protocol, staff shall be responsible to monitor individuals while eating for symptoms or behaviors that could lead to choking or aspiration and alert the nurse immediately, or as otherwise specified in the facility protocol. Staff will be responsible to initiate emergency procedures immediately upon encountering a choking victim.

(3) On the day of admission, every new resident shall be assessed, by a registered nurse or other qualified professional, for physical and behavioral factors that indicate an individual is at risk of choking or aspiration.

(A) The initial risk assessment should include, but not be limited to documentation of:

1. Any history of physical or behavioral eating problems such as a diagnosis of Dysphagia, aspiration, pneumonia or history of choking incidents/ precautions or aspiration pneumonia, order for thickened liquids;

2. Physical conditions that may impact safe intake by mouth (inability to maintain upright posture, increased fatigue, food texture changes, decreased dentition, gingivitis, periodontal disease, decayed teeth, hiatal hernia, ulcers, GERD/esophageal reflux, coughing before during or after the meal etc.);

3. Medication, affecting the swallow reflex, especially that which has an anticholinergic or sedative effect or which could cause motility or GI disturbances (see facility food and drug interaction references);

4. Medical diagnoses associated with Dysphagia (Tardive Dyskinesia, Rumination, Cerebral Palsy, Down's Syndrome, etc.);

5. Behaviors that could lead to choking or aspiration (pica, gulping, agitation, grabbing food, pacing while eating or drinking, eating times of less than 15 minutes, aversion to or refusal of food/liquids/medications; etc.).

(B) If potential problems are identified during the assessment, a special mealtime observation assessment shall be completed at the next meal by a registered nurse, occupational therapist, dietician, speech pathologist, or other professional qualified to do such assessments. This special observation shall include, but not be limited to, documented observation of:

1. Position during meals and up to one (1) hour after meals, including consideration of need for special positioning and/or adaptive equipment;
2. Food texture and liquid consistency;
3. Tremors/coordination interfering with ability to eat;
4. Need for adaptive devices;
5. Level of assistance required to feed self safely.
6. Ability to chew present food texture (dentition, tongue function, lip closure);
7. Swallowing dysfunction indicators: coughing, choking, wheezing, drooling, or gurgling/wet sounding breathing, voice quality changes, discomfort during meals (wincing, tearing of eyes, flesh color changes while eating etc.);
8. Behaviors that could lead to choking or aspiration, such as eating too fast (less than fifteen (15) minutes) or too slow (more than forty-five (45) minutes), stuffing food in mouth rapidly (especially without chewing), gulping liquids, running/pacing while eating.

(C) Results from the mealtime assessment indicating an individual is at risk shall be shared immediately with the registered nurse responsible for the individual. If the registered nurse determines that a potential for choking or aspiration exists, the registered nurse shall immediately inform the attending or on-call physician and the treatment team. The physician shall institute an immediate interim plan to prevent choking and aspiration. The interim plan shall include the degree and type of supervision required and shall remain in effect until the treatment or habilitation team develops a permanent plan. All observations and actions taken shall be documented in the individual's record.

(4) The treatment and habilitation plans for those at risk of choking or aspiration shall include objectives to prevent choking, including corrective interventions, such as meal cards, when needed.

(A) The treatment or habilitation team shall secure specialized assessments as needed (ear, nose, throat, dietary, pharmacy, speech pathology, occupational therapy, physical therapy, dental, Modified Barium Study (MBS), etc.).

(B) The individual's record shall be tagged according to facility practices to alert staff to acute problems (suicide precautions, serious allergic reactions, choking risk, aspiration risk, etc.).

(C) Discharge plans shall include consideration of the individual's choking and aspiration risk and shall ensure that future service providers are adequately aware of risks and interventions.

(D) A specific dietary order shall be secured from a physician (or nurse practitioner) at least 24 hours before a scheduled appointment or procedure in which an individual is to receive sedation.

1. The order should specify whether a regular diet can be maintained; or if a temporary change should be made to the individual's diet; such as NPO, clear liquids, dental soft or blended texture, etc.
2. If a temporary change is made, the order should stipulate the date/time the order is to become effective and for how long the temporary change is to be in effect.
3. The individual shall be assessed and cleared by a registered nurse or physician prior to returning to the previous diet/food texture.

(5) Choking and aspiration risk assessments shall be updated annually in accordance with section (3)(B) for all individuals previously identified with potential choking and aspiration problems.

(6) Choking and aspiration risk reassessments shall be completed in accordance with section (3)(B) when the following occurs:

(A) There is a change in the individual's condition that might affect eating/swallowing.
(B) The individual has a choking or aspiration episode.
(C) The individual has multiple tooth extraction.
(D) The individual has a stroke.

(7) All choking and aspiration incidents shall be documented and reported.

(A) All staff shall immediately verbally report all choking and aspiration incidents to the responsible on duty nurse. The nurse shall notify the attending or on-call physician as needed.

(B) Nursing staff shall report each choking and aspiration incident by the end of the next working day to the attending physician and the treatment or habilitation team.

(C) All incidents of choking and aspiration shall be documented in the client's record, using the form and mechanism designated by the facility.

(D) Each facility shall identify staff to gather data on the choking and aspiration incident and to maintain and analyze that data.

(E) Aggregate summary data on choking and aspiration incidents shall be submitted to the Department at the end of each calendar year by each division to the DMH Medical Director or his designee.

(8) Designated facility staff shall be trained to assist individuals at risk of choking and aspiration.

(A) During their orientation, designated staff shall receive comprehensive in-service on choking and aspiration prevention. Designated staff include those who prescribe or recommend diets; serve food and supervise meals; prepare meals or assist in preparing meals; plan, order, prepare or distribute edible re-enforcers; and plan activities involving food.

(B) Training on prevention/management of choking and aspiration shall include, but is not limited to:

1. All intervention, planning and reporting requirements contained in this

document;

2. The facility's emergency response system; and
3. Availability and location of facility resources relevant to managing and prevention of choking and aspiration problems. Resources include facility policies and procedures, food and drug interaction lists, use of mealtime cards and physical nutritional management plans, and dietary manuals.

(C) When choking or aspiration problems are identified, designated staff shall be trained to initiate and carry out procedures set out in the plans.

(D) Each facility shall augment its food and drug interaction references with information on medications known to affect swallowing, including those that cause sedation, dry mouth, tardive dyskinesia, and extra pyramidal symptoms.

(E) Each facility shall identify staff to coordinate staff training on choking and aspiration prevention/management and to maintain a current list of specialized resources on prevention and management of choking and aspiration.

HISTORY: Original DOR effective April 1, 1993. Rescinded November 1, 1993. Re-enacted with amendments effective November 1, 2006. On May 17, 2013 the sunset date was extended to July 1, 2016. On June 20, 2016 the sunset date was extended to July 1, 2019.